METHODS USED IN ESTABLISHING PAYMENT RATES

PRESCRIBED DRUGS (continued)
Additional Upper Limit Application

4/1/86 The upper limits described in previous sections apply in all cases where prescribed drugs are provided to Medicaid eligible recipients as a part of the state's Title XIX Medicaid Program. Should the state enter into a prepaid capitation arrangement, these limits will still apply and any contract between the state agency and the underwriter, carrier, foundation, HMO, or other insurers containing the terms of such prepaid capitation arrangements shall include a provision imposing the same upper limits for reimbursements of prescribed drugs.

METHODS USED IN ESTABLISHING PAYMENT RATES

10/1/80 RURAL HEALTH CLINIC SERVICES - Each rural health clinic will be reimbursed the same rate per visit established by the Title XVIII (Medicare) carrier Blue Cross/Blue Shield of Tennessee for Medicare. Medicaid will utilize the annual rate established by the Medicare carriers for reimbursement of Rural Health Clinics. In lieu of retroactive payment to a facility, a percentage allowance will be added to the per encounter rate as of July 1 of each year based on the clinic's last year-end cost report. The percentage allowance will be based on the Consumer Price Index (CPI) estimated for the month of the clinic's fiscal year end divided into the CPI projected for December of the following year. The established rate multiplied by this ratio will determine the clinic's rate per encounter for each subsequent twelve month period. The effective date of each rate change will be July 1 of each year. Other Title XIX ambulatory services will be reimbursed using the same methodology as specified elsewhere in the State Plan for those services.

Amendment 93-02
Effective 1/1/93
Supersedes 91-29

Approval _____

METHODS USED IN ESTABLISHING PAYMENT RATES

11/1/85 OUTPATIENT HOSPITAL SERVICES - Are reimbursed according to the methodology described in Exhibit I of this attachment.

METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/90 HOSPICE CARE SERVICES - Medicaid reimbursement to hospice providers is the same as their Medicare established rate for the following four categories of service: 1) routine home care; 2) continuous home care; 3) inpatient respite care; and 4) general inpatient care.

These rates have been established based on a Medicare hospice national rate, adjusted for regional differences in wages, using indices published in the Medicare Hospice Manual.

In addition, Medicaid will reimburse the hospice for physician services such as direct patient care services, furnished to individual patients by hospice employees and for physician services furnished under arrangements made by the hospice. These physician fees are reimbursable at the established Medicaid rate for physician services.

For Medicaid eligible recipients residing in an ICF or SNF facility who have elected to receive hospice services, the hospice provider will be paid the routine or continuous home care rate plus an additional amount for room and board.

For dual eligible recipients residing in an ICF or SNF facility who have elected to receive hospice services and whose hospice services costs are covered by Medicare, Medicaid will make an additional payment to the hospice provider for room and board.

The following is the methodology used in determining the room and board rate for nursing home hospice patients. An amount equal to 95% of what the state payment would have been to the nursing home will be paid to the hospice. It will be based upon the weighted average of days paid to each nursing home that the hospice has made payment to in the previous fiscal year. Those weights will be applied to 95% of the current nursing home rates to develop a weighted average rate that will be paid to the hospice for each of its nursing home clients. In the event the hospice provider has no history, the provider will be paid 95% of the average nursing home rate in the county the hospice resides. This average will be weighted based on Medicaid days.

Amendment 93-02
Effective 1/1/93
Supersedes 89-22

Approval _____

10/1/90 **Respiratory Services**: Payments are based on a fee schedule determined by the state agency and will not exceed the upper limit established through the application of the parameters of 42 CFR 447.304.

10/1/90 **Personal Care Services**: Reimbursement of personal care services is based on a fee schedule determined by the state agency and will not exceed the upper limit established through the application of the parameters of 42 CFR 447.304.

10/1/90 **Private Duty Nursing**: Reimbursement is based on a fee schedule determined by the state agency and will not exceed the upper limits established through the application of the parameters of 42 CFR 447.304.

10/1/90 **Therapies**: Reimbursement is based on a fee schedule determined by the state agency and will not exceed the upper limits established through the application of the parameters of 42 CFR 447.304.

10/1/90 **Prosthetic Devices and Orthotics**: Reimbursement is based on a fee schedule determined by the state agency and will not exceed the upper limits established through the application of the parameters of 42 CFR 447.304.

METHODS USED IN ESTABLISHING PAYMENT RATES

4/1/92 INDEPENDENT LABORATORY AND PORTABLE X-RAY SERVICES - Payments are the lesser of the provider charges or the Medicaid maximum allowable fee schedule which is equivalent to the 1986 Medicare Part B, fiftieth percentile, Area B allowance, not to exceed the current upper limit payment of Medicare.

Amendment 93-02
Effective 1/1/93
Supersedes NEW

Approval APR [illegible] 1993

METHODS USED IN ESTABLISHING PAYMENT RATES

4/1/91 EARLY AND PERIODIC SCREENING AND DIAGNOSIS OF INDIVIDUALS UNDER 21 YEARS OF AGE, AND TREATMENT OF CONDITIONS FOUND:

All services provided for in Section 1905(a) of the Act which are medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions are provided for EPSDT participants.

Institutional services (inpatient/outpatient hospital services, nursing home services and ICF/MR services), Federally Qualified Health Centers and Rural Health Services are reimbursed based on cost reports as described within Attachment 4.19-B.

All other services are reimbursed on a fee-for-service basis in accordance with established fee schedules as described within Attachment 4.19-B.

METHODS USED IN ESTABLISHING PAYMENT RATES

10/1/90 EYEGLASSES/CONTACT LENSES - Reimbursement for eyeglasses and contact lenses are based on a fee schedule established by the state agency.

METHODS USED IN ESTABLISHING PAYMENT RATES

10/1/90 HEARING AIDS - Reimbursement is based on negotiated contract prices with hearing aid manufacturers. In no case will the payment for a hearing aid exceed the customary charge for a provider or the Medicaid fee schedule.

METHODS USED IN ESTABLISHING PAYMENT RATES

7/1/90 INDIVIDUAL PRACTITIONERS SERVICES - (Doctors of Medicine, Chiropractic, Osteopathy, Dentistry, Optometry and other individual Practitioners services) - Individual payments are based on a fee schedule or a fee schedule developed for provider specialty groups determined by the state agency and will not exceed the upper limits established through application of the parameters at 42 CFR 447.304. Physicians who perform services for neonates or high risk obstetrical recipients in RPICC disproportionate share hospitals will be reimbursed payments based on the estimated average length of time and services required to treat an ill infant or high risk mother.

4/1/99 Medicaid will not reimburse doctors of medicine, chiropractic, osteopathy, and other individual practitioner services for mobile services except under contractual agreement with a Federally Qualified Health Center, a Rural Health Clinic or a County Health Department.

Medicaid will not reimburse doctors of optometry for mobile services except under contractual agreement with a Federally Qualified Health Center or Rural Health Clinic.

Medicaid will not reimburse doctors of dentistry for mobile services except under contractual arrangement with a Federally Qualified Health Center, County Health Department or for services rendered to recipients age 21 and over at nursing home facilities.

Medicaid will not reimburse for mobile services for radiology procedures or interpretations if the service was provided by a mobile provider.

Amendment 99-03
Effective 4/1/99
Supersedes 93-02

Approval _____